UTAH DEPARTMENT OF HEALTH PRIOR AUTHORIZATION REQUEST FORM

ZOFRAN (ondansetron hcl)**, KYTRIL**(granisetron)**, ANZEMET**(dolestron mesylate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____Medication_____

All information to be legible, complete and correct or form will be returned

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CRITERIA FOR PREGNANCY:

FAX DOCUMENTATION FROM PROGRESS NOTES

- **Pregnancy** related hyper-emesis exceeding 1 week
- Failure to respond to other medications including at least a trial of pyridoxine,and phenothiazines for current pregnancy **and/or**
- Has received IV re-hydration with imminent hospital admission if vomiting cannot be otherwise controlled

RE-AUTHORIZATION FOR PREGNANCY

Review and approval required by Drug Utilization Review Board

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CRITERIA FOR CHEMO, RADIATION THERAPY, AND POST-OP NAUSEA:

TELEPHONE AUTHORIZATION

- Prevention of hyper-emesis associated with initial and repeat courses of **cancer treatment with chemotherapy**
- Prevention of hyper-emesis associated with **radiation therapy** in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen.
- Prevention **post-op hyper-emesis**

RE-AUTHORIZATION:

Telephone request from doctors office